

(1) Make statements of deficiencies based on the survey reports available for inspection and copying in both the public assistance office and the Social Security Administration district office serving the area where the provider is located; and

(2) Submit to the Regional Medicaid Director, through the Medicaid agency, a plan for making those findings available in other public assistance offices in standard metropolitan statistical areas where this information would be helpful to persons likely to use the health care provider's services.

(g) *When documents must be made available.* The disclosure procedure must provide that the State survey agency will—

(1) Retain in the survey agency office and make available upon request survey reports and current and accurate ownership information; and

(2) Make available survey reports, findings, and deficiency statements immediately upon determining that a health care provider is eligible to begin or continue participation in the Medicaid program, or within 90 days after completion of the survey, whichever occurs first.

(h) *Evaluation reports on providers and contractors.* (1) If the Secretary sends the following reports to the Medicaid agency, the agency must meet the requirements of paragraphs (h) (2) and (3) of this section in releasing them:

(i) Individual contractor performance reviews and other formal performance evaluations of carriers, intermediaries, and State agencies, including the reports of followup reviews;

(ii) Comparative performance evaluations of those contractors, including comparisons of either overall performance or of any particular aspect of contractor operations; and

(iii) Program validation survey reports and other formal performance evaluations of providers, including the reports of followup reviews.

(2) The agency must not make the reports public until—

(i) The contractor or provider has had a reasonable opportunity, not to exceed 30 days, to comment on them; and

(ii) Those comments have been incorporated in the report.

(3) The agency must ensure that the reports contain no identification of individual patients, individual health care practitioners or other individuals.

[43 FR 45188, Sept. 29, 1978, as amended at 44 FR 41644, July 17, 1979; 59 FR 56232, Nov. 10, 1994]

#### § 431.120 State requirements with respect to nursing facilities.

(a) *State plan requirements.* A State plan must—

(1) Provide that the requirements of subpart D of part 483 of this chapter are met; and

(2) Specify the procedures and rules that the State follows in carrying out the specified requirements, including review and approval of State-operated programs.

(3) To an NF or ICF/MR that is dissatisfied with a determination as to the effective date of its provider agreement.

(b) *Basis and scope of requirements.* The requirements set forth in part 483 of this chapter pertain to the following aspects of nursing facility services and are required by the indicated sections of the Act.

(1) Nurse aide training and competency programs, and evaluation of nurse aide competency (1919(e)(1) of the Act).

(2) Nurse aide registry (1919(e)(2) of the Act).

[56 FR 48918, Sept. 26, 1991, as amended at 62 FR 43935, Aug. 18, 1997]

#### Subpart D—Appeals Process for NFs and ICFs/MR

SOURCE: 44 FR 9753, Feb. 15, 1979, unless otherwise noted.

#### § 431.151 Scope and applicability.

(a) *General rules.* This subpart sets forth the appeals procedures that a State must make available as follows:

(1) To a nursing facility (NF) that is dissatisfied with a State's finding of noncompliance that has resulted in one of the following adverse actions:

(i) Denial or termination of its provider agreement.

(ii) Imposition of a civil money penalty or other alternative remedy.